Minutes of the Meeting of the Adult Social Care & Health Select Committee held in the Committee Room 1, Town Hall, Hornton Street, W8 7NX at 6.30 pm on Thursday, 12 October 2023

PRESENT

Committee Members

Cllr Lucy Knight (Chair)
Cllr Anne Cyron (Vice-Chair)
Cllr Gerard Hargreaves

Others Present

Cllr Josh Rendall, Lead Member for Adult Social Care & Public Health
Cllr Linda Wade
Cllr Mary Weale
Dr Andrew Steeden, Borough Medical Director, NHS North West London
James Benson, Place Based Partnership Director and Chief Executive Officer
Jane Wheeler, Director, Local Care, NHS North West London
Navneet Willoughby, Director of Operations, NHS North West London

Council Officers

Emily Beard, Governance Officer
James Diamond, Scrutiny & Policy Officer
David Bello, Head of Mental Health Services & Substance Use Team
Manisha Patel, Director of Adult Social Care Governance Operations
Anna Raleigh, Director of Public Health
Gareth Wall, Bi-Borough Director of Integrated Commissioning
Visva Sathasivam, Director of Social Care

1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllrs. Mona Ahmed, Stuart Graham, Sam Mackover and Portia Thaxter.

2 DECLARATIONS OF INTEREST

No declarations of interest were made.

3 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 29 June 2023 were confirmed as a correct record.

4 HOMECARE TRANSFORMATION PROGRAMME UPDATE REPORT

The Chair invited the Lead Member for Adult Social Care and Public Health, Cllr. Rendall, supported by Gareth Wall to introduce the report and the following points were highlighted:

1. Most users were impressed by the services, however, there had been some teething problems.

2. The services helped people to get discharged from hospital and remain independent. Most of the time it was the preferred means of receiving care for users.

3. On average, the Council provided services to 600 residents across the borough and 2,700 hours were commissioned.

4. The programme had been ongoing for a few years, with some stops and starts due to the pandemic and staff changes, however, it was now back on track.

5. The timeline included issuing the Procurement Strategy in December 2023 and going out for tender in February 2024, with contracts beginning in the middle of next year (2024).

6. There had been a lot of time spent talking to residents, users and their families to understand what 'good' looks like to them and how they liked to access homecare.

7. Some things would be decommissioned, such as the electronic call monitoring system, as it was littered with problems in practice.

8. Regarding workforce, the risk had increased due to changes in the pattern of stable recruitment and the composition of the workforce. There had been a slight increase in the percentage of workforce coming from within the borough (32%), however, there had been a decrease in the recruitment of people from European Union (EU) countries. This had been partially offset by an increase of those coming from non-EU countries but there were issues around the cost of the legal process and retention of those workers. There was a Market Sustainability and Improvement Fund from the Government which would be utilised next year.

The Chair then invited questions from the Committee who:

1. Asked whether there was more which could be done to address the workforce challenges around recruitment and retention and whether there were any learnings from the issues with the Care Quality Commission's rating for MiHomecare. Gareth Wall noted that there were learnings which they could do more of and explained that pay was a key issue in the sector. The Council was a London Living Wage paying commissioning organisation and the overall rate with agencies was £21.21 per hour, which was competitive when benchmarked across London. The Council was looking at adjusting the size and shape of the geographical patches to reduce the need for travel time within patches and to build familiarity for staff and users. It was difficult to make time for staff to do other things, such as sharing experiences with

colleagues, due to the way their time was costed. The Lead Member added that workforce was an issue in a lot of sectors and the borough was an expensive place to live. There were 300 key worker accommodation being built which would allow workers to live and work in the borough.

2. Acknowledged that it had been a while since homecare had been tendered and queried how changes would be accounted for when producing the tender document. Gareth Wall responded that one of the overarching aspects that they were looking to introduce was an iterative contract, to enable changes to be made over time. There was currently an outcomes pilot underway which changed the approach to making arrangements as a time and task model expressed in hours and visits per day, which put the cost on outcomes instead. This should create good value, increase satisfaction and build on good practice of person-centred care. The Council was also looking to introduce a digital platform which would be a facility for people to manage their care and direct payments themselves if they would like to.

3. Questioned why spot providers were necessary and whether the Council could reduce their reliance on them. In response, Gareth Wall admitted that it was not the ideal arrangement and it was partly a consequence of the size of the geographical patches, and that under the current contract, the Council was required to accept 100% of referrals which was not practical. The hope was to move from an activity-based contract to a core and flex model, where secondary providers would be under contract, as well as some specialist providers.

4. Enquired what a user would notice from their care that was different to what they currently received. Gareth Wall explained that it would include choice of care and, if a stable workforce was achieved, stable and consistent care.

5. Queried how the transformed service would help a user achieve goals, such as swimming more. Gareth Wall shared that a user could express ambitions in their care path regarding their health and wellbeing and their social care worker could assist them in making trips outside of the home to achieve their goals. This would be integrated with the work of a personal assistant if they had one.

6. Noted that some users struggled with direct payments and needed more help with them. Gareth Wall explained that users often got put off by the level of detail and the digital platform removed the detail and allowed a user to see their bank account balance and marketplace to choose their care, within the bounds of their care plan. The Councillor responded that increased choice could make it more confusing for the user. Gareth added that there was a new direct payments team in place to help, as well as being picked up during the annual review and assessment process.

7. Asked about the challenges of providing care to someone with complex needs. Gareth Wall explained that it was particularly challenging in terms of hospital discharge, as two care workers would be required, and thus, there was an associated cost and coordination to consider. Sometimes the Council would pay a higher rate for a specialist worker, and this allowed agencies to make the investment.

8. Enquired about the expected MiHomecare CQC report. Gareth Wall shared that they would share the report with the Committee when it was published and they were reasonably confident that, when reinspected, it would come out of the 'requires improvement' rating.

Action: *Director of Integrated Commissioning*

9. Questioned whether the team was confident that they would meet the timescales. In response, Gareth Wall confirmed that he was confident because a lot of the products and documentation was already done but not finalised yet. There was contingency built into the contracts to allow for long lead times for mobilisation.

10. Queried whether there was a local authority in the UK which the Council was looking to for best practice. Gareth Wall explained that Lewisham had introduced a new model which they were looking at, which made time for homecare staff to get together and share experiences. They had also changed the name to local health and wellbeing work in attempt to attract new staff. Overseas there were models which would be explored to see if they could be appropriate in the future, such as the Buurtzorg model in the Netherlands.

11. Asked if a briefing could be provided to the Committee, outside of the formal Committee meetings. The Committee would then provide their feedback and understanding to a public meeting.

Action: *Director of Integrated Commissioning*

Actions to be completed, with information requested by the Committee to be sent to the Governance Officer for circulation:

1. The Director of Integrated Commissioning to provide the CQC MiHomecare report when published.

2. The Director of Integrated Commissioning to provide a briefing to the Committee on the progress of the Homecare Transformation Programme, including procurement.

The Lead Member for Adult Social Care and Health left the meeting at 7:19pm.

5 REVIEW OF PALLIATIVE CARE SERVICES IN NORTH WEST LONDON

At the Chair's invitation, Jane Wheeler, Director, Local Care (NHS NWL), introduced the report assisted by Dr Andrew Steeden, Borough Clinical Lead (NHS NWL), James Benson, Chief Executive (CLCH), and Navneet Willoughby, Director of Operations (CLCH). The introduction included the following points:

1. There had been a period of strong engagement across North West London (NWL) providing an opportunity to improve palliative care services for residents, including increasing the total number of community beds available across NWL.

2. There was an unmet need for those that may not need specialist services but are unable to remain in home and do not need to be in hospital. It was particularly difficult for residents who live alone, and they need supportive wraparound services.

3. Residents do not know where to go for advice and thus, the new model of care would introduce a 24/7 specialist palliative care advice line which residents and their carers could use. As well as introducing bereavement and counselling services.

4. The model of care document does not include how services would be commissioned as this would form the next stage of the process, with formal consultation early next year (2024).

5. A decision had not yet been made regarding the Pembridge Hospice (Pembridge); this would be included in the next stage which will look at placement of beds.

6. Lockdown resulted in an increase of people who wanted to be supported within their own home and it transformed the way care as provided.

The Committee proceeded to discuss the report and the following points were made:

1. Welcomed additional opening hours, adult community specialist teams and, hospice at home. Asked for a verbal update on the recent meetings with the community about Pembridge. Officers responded that the model of care group wanted to start discussing Pembridge and they expressed that the NHS had not been as open to ideas about reopening. Officers and the group discussed ideas, and outputs of the sessions would be published on their website. Officers confirmed that they did not have an agenda to open or close the Pembridge; they wanted to maximise services. At some stage, a decision needed to be made on how long to consider reopening it or to reallocate the funding and come to a resolution. The consultant workforce for Pembridge had proved difficult to find and a range of other health professionals would also be required.

2. Expressed concern about how long it had been since the temporary closure of Pembridge and asked if all avenues were being explored in terms of recruitment. Officers explained that consultant recruitment was currently underway and two different job descriptions were to be advertised, with one being hybrid between inpatient and community work. Once approved by the Royal College, they would go out for recruitment, which would include looking abroad. The Committee noted that it would be hard to recruit if the future of Pembridge was unknown. In response, officers explained that this was a key challenge and the timeline was very important. They wanted to understand the deliverability of roles and if no one was available, then this would impact the deliverability of the model of care.

3. Queried the timeline for the decision. Officers clarified that formal consultation could begin in January 2024, which would usually last 12 weeks. A ten and a half week consultation period may be requested to account for

the pre-election period and to prevent any delays to making a decision in June.

4. Acknowledged the difficulties there had been to receive responses to the surveys but emphasised the importance of feedback and enquired as to whether there was a sensitive way of receiving it. Officers explained that staff were asking residents who would have never received care at the Pembridge and thus, it was a challenge. The key impact was around travel. The share of beds at Pembridge for Kensington and Chelsea residents was approximately four beds and 30-40% of those needed more generalised beds but they did not exist. Officers noted the importance of having inpatient beds within the North Kensington area, however, they did not necessarily have to be specialist beds in the Pembridge. Some residents missed out on the right palliative care they needed because Pembridge was so specialist.

5. Queried about the site of generalist beds. Officers explained that that there was a need for beds for people that have less complex needs which were usually in a community setting and rarely in an acute hospital setting. It could involve a consultant round weekly rather than being there all the time. It was also important that they were located in geographically accessible places.

6. Questioned the proposed sites and how quickly it could be set up. In response, officers explained that within in the borough, available space was largely in North Kensington. Timescales would be dependent on the current recruitment and working out how to restart an inpatient service. It could be a process of opening some of the unit, increase the total working hours and train staff, and then fully open the unit. Once a model is agreed, it will allow partners to work in a different way. Officers apologised that the process had taken a long time and they understood the impact. The current proposal was an improvement on what had previously been considered. The data was not showing an increase of those wanting to be supported in hospital, however, tracking choices was always difficult. The engagement in November was about options and the criteria. Officers had tried to be honest about was achievable.

7. A Healthwatch representative queried that if a decision was made in June, then the recruitment to make that happen would have to follow. Officers explained with consultant recruitment, it was important to remain open and transparent about what was happening. Job plans could also be amended once it is understood what consultants are looking for. Opening a consultant-supported unit was different to opening a consultant-led unit and it could be achieved through a phased opening.

8. Noted that 3,000 beds would be required by 2030 and asked how officers had been preparing for that. It was explained that this was a five year strategy and it included capacity planning that would last for seven years. At the seven year point, the demand would outgrow the capacity. There would be a two year implementation plan and then discussions would start to be had about what needs to be done next. There were other areas that could be focused on instead, such as children’s end of life care.

9. Asked about the budget and resources, as there were not included in the report. Officers clarified that they would be included in the next stage. There were sets of funding tied up in the system now whilst this process was being worked through. Officers believed that the proposed model of care is deliverable with the funding available and they would be openly engaging on the options.

6 SUICIDE PREVENTION AND ADULT MALES AS A HIGH-RISK GROUP - WORKING GROUP

The Chair introduced the report, explaining that the Committee reviewed the Suicide Prevention Strategy in May 2023, and it was noted that there was a high rate of suicide among adult males. It was proposed for a Working Group to be established to look into this area.

The Committee RESOLVED to agree the Working Group membership and terms of reference.

7 WORK PROGRAMME REPORT

The Committee agreed that a briefing would be taken outside of the formal meetings on the progress of the Homecare Transformation Programme and they would report back to Committee with their findings and conclusions.

It was suggested to add palliative care to the future work programme. James Diamond suggested to keep a watching brief on it and that the NHS officers would come back at the Committee's request to update them. It was also noted that the Committee could bring their findings to the attention of Full Council.

It was agreed by the Committee to receive a written update on Covid-19 from the Director of Public Health.

The Committee noted the actions and responses to recommendations.

8 ANY OTHER ORAL OR WRITTEN ITEMS WHICH THE CHAIR CONSIDERS URGENT

There were none.

The meeting ended at 8.15 pm

Chair